

ABSTRACT
SOCIAL WORK

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THE EFFECTS OF REALITY ORIENTATION ON CONFUSED
ELDERLY NURSING HOME RESIDENT

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The purpose of this study was to examine the effects of individualized reality orientation therapy on paranoid behavior in a nursing home resident diagnosed with dementia. There were two hypotheses, the first one hypothesized that reality orientation therapy would increase the resident's awareness of environment. The second hypothesized that reality orientation therapy would produce a decrease in verbal statements of paranoid delusions by the resident. This study was conducted over a nine week period. The design of the study was a single A-B case study. The results showed a decrease in statements by the resident of verbal abuse, physical abuse, and neglect. Findings indicated that the resident experienced improvement from the intervention.

THE EFFECTS OF REALITY ORIENTATION ON CONFUSED
ELDERLY NURSING HOME RESIDENT

A THESIS

SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
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THE DEGREE OF MASTER OF SOCIAL WORK

BY

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CHAPTER ONE

INTRODUCTION

The elderly are increasing exponentially in number. There are over thirty million elderly people in America. Only five million elderly persons existed when Franklin Delano Roosevelt signed into law the Social Security Act of 1935.¹ The life span at the beginning of Social Security was sixty-three years. Elderly were defined as those persons existing two years past the average life span. Today society continues to define elderly by the same age; however, the average life expectancy of a person at age sixty-five is nineteen years.²

The average life span of the elderly with diagnosed dementia is approximately three years, as opposed to nine years for non-demented aged mated controls. Dementia is the most common diagnosed mental illness among the elderly. Dementia is diagnosed in 50 to 80 percent of elderly nursing

¹K. Scala, American Guidance for Those Over 60 (Falls Church, Va.: Shariff Publications, Inc., 1988), 112.

²F. Cawthon, "Old in America: Aging with Attitude," The Atlanta Journal, 2 April 1991, 3(C).

home residents.³ The majority of the elderly live outside institutionalized care; however, as many as 60 percent may be diagnosed as neurotic, personality disorder, and psychiatric impairment.⁴

The primary role of the nursing home industry, when caring for with the elderly dementia residents, is to provide custodial care and insulate society from abnormal behavior.⁵ There have been few studies on the orientation of residents into nursing home environments. The maintenance of cognitive ability in adaptation to institutionalized surroundings has received little effort from the industry itself. Since their inception, nursing homes have placed residents' physical needs, almost exclusively, as the direction of treatment efforts.⁶

While the overwhelming majority of nursing home residents are diagnosed with some degree of confusion, few are formally oriented to the health care setting. The decline of all senses as a natural event of aging

³Sally R. Esser and Peter P. Vitaliano, "Depression, Dementia, and Social Supports," International Journal of Aging and Human Development 26, no. 4 (1988): 291.

⁴S. Kohut, Jr., J. J. Kohut, and J. J. Fleishman, Reality Orientation for the Elderly 3d ed. (Oradell, N.J.: Medical Economic Company, Inc., 1987), 15.

⁵Judith M. Richter, "A Need for Social Support: The Chronically Mentally Ill Institutionalized Elderly," Journal of Gerontological Nursing 16, no. 8 (August 1990): 32.

⁶A. J. Rosin and others, "Environmental Management of Senile Dementia," Social Work in Health Care 11, no. 1 (Fall 1985): 41.

contributes to the mental illness of population at high risk of disease. Only recently have geriatric analysts highlighted the importance of concomitant psychosocial programs despite the effects of mortality in diagnosis and the potential to erroneous label confusion.⁷

Statement of the Problem

The high percentage of elderly in nursing homes diagnosed with dementia leads one to believe that it is a natural course of old age. Mental impairment is more likely to be a result of illness, and the elderly are more prone to be ill. Memory problems are thus more prevalent among elderly as a result of such illnesses not connected with cognitive ability.⁸ It is possible that memory loss associated with illness is the cause of many misdiagnosed dementias.

In nursing home residents who have some degree of mental impairment, the condition may be exaggerated by environmental conditions such as institutionalization. Inappropriate expectations from caregivers in the institutional environment may also affect diagnosis.⁹

⁷Ibid., 42.

⁸Kathleen Carroll and Katherine Gray, "Memory Development: An Approach to the Mentally Impaired Elderly in the Long-Term Care Setting," International Journal of Aging and Human Development 13, no. 1 (1981): 16.

⁹Ibid.

The validity of a diagnosis is difficult to determine in dementia due to its nature. Dementia is an organic illness, therefore the majority of cases can be properly diagnosed after autopsy. The diagnosis of dementia is frequently arrived at by exclusion of symptoms of other diseases. The actual diagnosis is dynamic and based upon continuous assessment.

Dementia does not seek to explain cause other than an organic basis. It is used to summarize a variety of symptoms only. Dementia is both reversible and irreversible. The primary features of dementia are deficits in memory, judgement, concentration and verbal ability, all of which are affected by social interaction as well as general health. Reversible dementia affects 25-50% of all persons with dementia.¹⁰ It is diagnosed as *primary degenerative dementia* with senile onset. Residents with reversible dementia generally have a shorter duration of symptoms and less cognitive impairment.¹¹

The esoteric nature of diagnosis is based on symptoms, not cause. The onset of symptoms used in diagnosis are also caused by abnormal physiological and psychological conditions which persist in the environment of institutionalized care. The dynamic assessment of symptom

¹⁰R. R. Greene, Social Work with the Aged and Their Families (New York: Aldine de Gruyter, 1986), 58.

¹¹Esser and Vitaliano, "Depression," 291.

allows for improvement as well as degeneration in functioning.

Purpose of the Study

The central purpose of this study was to examine the effects of reality orientation on verbal complaints related to confusion in a nursing home resident diagnosed with dementia.

CHAPTER TWO

LITERATURE REVIEW

Numerous studies have cited reality orientation as a corrective therapy for dementia and confusion in nursing home residents. The literature review consists of studies which discuss reality orientation and dementia.

Reality orientation therapy was determined to be a useful rehabilitation therapy in a study conducted by Sinebruchow and Holden. The study focused on elderly hospitalized patients in a clinical setting. Residents receiving reality orientation therapy were found to function higher on rating scales in areas of communication, apathy, social disturbance and degree of physical disability, than residents who received normal care.¹

Nodhturft and Sweeney explored the difference in mental status of institutionalized elderly receiving reality orientation therapy to a control group of similar population. The theoretical framework for the study is disengagement theory. Evidence supports the hypothesized correlation between reality orientation therapy and degree

¹Una P. Holden and Alex Sinebruchow, "Reality Orientation Therapy: A Study Investigating the Value of This Therapy in the Rehabilitation of Elderly People," Age and Ageing 7 (1978): 83-90.

of confusion and isolation. Findings suggest that elderly residents receiving reality orientation were less likely to become withdrawn and socially isolated.²

Behavioral improvement is one of the original goals of reality orientation, which seeks higher physical functioning integrated with other life skills such as ambulation, activities of daily living, communication and socialization.³ Hussian suggested greater emphasis on skill training should be incorporated into reality orientation therapy to improve clinical significance.⁴ Physical gains in verbal orientation by reality orientation are recognized; however, few improvements are experimentally significantly consistent across other behaviors in areas other than cognition.⁵ There are several studies which refute the notion that reality orientation is simply rote memorization of otherwise meaningless symbols.

Behavioral improvement, as well as cognitive gains were cited in the results of a study of environmental

²Elise I. Gropper-Katz, "Reality Orientation Research," Journal of Gerontological Nursing 13, no. 8 (August 1987): 14-15.

³Geneva Scheihing Folsom, "'Worth Repeating' Reality Orientation: Full Circle" Activities, Adaptation and Aging 8, no. 4 (June 1986): 71.

⁴Jane E. Fisher and Laura L. Carstensen, "Behavior Management of the Dementias," Clinical Psychology Review 10 (1990): 613.

⁵James T. Deitch, Linda J. Hewett, and Sue Jones, "Adverse Effects of Reality Orientation," Journal of the American Geriatrics Society 37, no. 10 (October 1989): 974.

manipulation using reality orientation. Reeve, Williams, Ivison and Kavanagh treated ten institutionalized elderly subjects with reality orientation and environmental manipulation. The treatment group was found to have significantly higher cognitive scores across multiple measures. The treatment group's performance in quantified improvements on behavioral measurements was insignificant; however, some gains were realized over the control group. More importantly the experimental group maintained a prior level of behavioral functioning throughout the study. This stability was a victory of sorts over a population which conventional wisdom, as well as control group data, supports a general behavioral functioning deterioration over the length of a study.⁶

Reeve and Ivison expounded the previous study to include classroom reality ordination training. Another hypothesis was added stating that reduced frequency of reality orientation will maintain the improvements gained in their earlier study. The hypothesis was confirmed. Behavior and cognitive functioning was improved significantly in the original design across a four week intensified therapy group. The improvements were also

⁶Ray Williams and others, "Use of Environmental Manipulation and Modified Informal Reality Orientation with Institutionalized, Confused Elderly Subjects: A Replication," Age and Ageing 16 (September 1985): 315-318.

maintained with progressive reductions in therapy across a three-month period.⁷

Reality orientation was found to produce improvements in verbal orientation, spontaneous verbal ability, and correct verbalization in the study by Harris and Ivory. The study contrasted institutionalized elderly receiving reality orientation to the same population group receiving normal treatment. All verbal categories produced improvements in the experimental therapy group. There was also a strong, although non-significant, trend for reality orientation patients to engage in more appropriate interactions with others following treatment.⁸

Woods sought to replicate earlier finding that reality orientation therapy, when administered to institutionalized elderly residents, produced marked improvement in behavioral, cognitive and orientation abilities. The study also explored the effects of staff attention in contrast to actual therapy. Attention of staff toward patients appeared not to be a factor of gains in therapy. Elderly residents exposed to reality orientation therapy performed consistently superior to residents receiving the same amount

⁷Wayne Reeve and David Ivison, "Use of Environmental Manipulation and Classroom and Modified Informal Reality Orientation with Institutionalized, Confused Elderly Patients," Age and Ageing 14 (March 1987): 119-21.

⁸Clarke S. Harris and Peter B. C. B. Ivory, "An Outcome Evaluation of Reality Orientation Therapy with Geriatric Patients in a State Mental Hospital," The Gerontologist 16, no. 6 (December 1976): 496-503.

of staff attention. The control group in the study actually deteriorated significantly in cognitive ability and memory, suggesting that the wrong form of attention is worse than no special treatment at all.⁹ Group reality orientation is believed to attack mental deterioration by two methods: constant stimulation through repeated presentation of fundamental information, and competition with peers which force the resident out of social isolation.¹⁰

Generalized behavioral improvements, specifically in areas involving activities of daily living, have been noted in long term regressive patients. The patients sufficiently improved to the extent that they were able to live outside of a hospital setting after exposure to reality orientation for prolonged periods.¹¹

Environmental factors of institutionalized residents exposed to reality orientation therapy was the focus of study of Citrin and Dixon. The demands of institutional environments were examined as a basis for milieu therapy. The underlying assumption is that typical activities of

⁹R. T. Woods, "Reality Orientation and Staff Attention: A Controlled Study," British Journal of Psychiatry 134 (May 1979): 502-07.

¹⁰Jonathan A. Barnes, "Effects of Reality Orientation Classroom on Memory Loss, Confusion, and Disorientation in Geriatric Patients," The Gerontologist 14, no. 2 (April 1974): 138-43.

¹¹Louise J. Browne and Jennie J. Ritter, "Reality Therapy for the Geriatric Psychiatric Patient," Perspectives in Psychiatric Care 10, no. 3 (1972): 136.

daily living are not encouraged by the staff in institutionalized settings. There is little or no insistence upon the residents to perform otherwise normal behaviors. The lack of use is believed to cause extinction of those behaviors over an extended time. Reality orientation was proved to be a reliable form of milieu therapy. The therapy, as a treatment technique, can be characterized as a method of reorganizing the social structure of the institutionalized environment so that residents are encouraged and allowed to behave in a more oriented fashion.¹²

Greene, Timburg, Smith, and Gardiner studied the effects of reality orientation when performed in a residential environment setting. The main interest of the study was the generalized effect on behavior at home. Results were significantly measured in patient mood at home as rated by relatives.¹³

Reality orientation techniques are most effective if they reduce an encoding deficit, optimize a strong memory trace, and provide retrieval aids.¹⁴ Reality orientation

¹²Richard S. Citrin and David N. Dixon, "Reality Orientation: A Milieu Therapy Used in an Institution for the Aged," The Gerontologist 17, no. 1 (February 1977): 39-43.

¹³J. G. Greene and others, "Reality Orientation with Elderly Patients in the Community: An Empirical Evaluation," Age and Ageing 12 (February 1983): 38-43.

¹⁴Ian Hanley, "Theoretical and Practical Considerations in Reality Orientation Therapy with the Elderly," in Psychological Approaches to the Care of the Elderly, ed. Ian

therapy is therefore viewed as a useful and primary tool in memory development programs, especially when paired with other complimentary therapies, such as reminiscence therapy and dexterity workshops.¹⁵

Reminiscence therapy was paired with reality orientation in the study by Baines, Saxby and Ehlert. Both therapies explored similar behaviors and focused on cognitive, emotional and behavioral changes in the institutionalized elderly. The objective of therapy included relearning conversational skills, cooperating in social activities and motivation. The pairing of therapies proved stimulating and motivational to both residents and staff. There was also some evidence to suggest possible long term effects of satisfaction and enjoyment in residential social activities.¹⁶ This result reflects the earlier findings of Goldwasser, Auerbach and Harkins of significantly affected level of depression in elderly

Hanley and John Hodge (London: Croom Helm, 1984), 168.

¹⁵Kathleen Carroll and Katherine Gray, "Memory Development: An Approach to the Mentally Impaired Elderly in the Long Term Care Setting," International Journal of Aging and Human Development 13, no. 1 (1981): 27.

¹⁶Shelia Baines, Peter Saxby, and Karen Ehlert, "Reality Orientation and Reminiscence Therapy: A Controlled Cross-over Study of Elderly Confused People," British Journal of Psychiatry 151 (August 1987): 223.

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Hanley and John Hodge (London: Croom Helm, 1984), 168.

¹⁵Kathleen Carroll and Katherine Gray, "Memory Development: An Approach to the Mentally Impaired Elderly in the Long Term Care Setting," International Journal of Aging and Human Development 13, no. 1 (1981): 27.

¹⁶Shelia Baines, Peter Saxby, and Karen Ehlert, "Reality Orientation and Reminiscence Therapy: A Controlled Cross-over Study of Elderly Confused People," British Journal of Psychiatry 151 (August 1987): 223.

institutionalized residents receiving reminiscence therapy in groups, such as those formed in reality therapies.¹⁷

Reality orientation and sheltered workshops were evaluated against an assignment control group in the study by MacDonald and Settin. Nursing home residents were randomly assigned to one of two groups in three experimental conditions. The results were presented by six measurement scales. Sheltered workshop treatment produced significant gains in life satisfaction while reality orientation produced non-significant decrements in life satisfaction scores.¹⁸

Degree of dementia as a variable was the aim of the hypothesis in a study by Hanley, McGuire and Boyd. Reality orientation failed to produce behavioral changes among the experimental group. There was also no significant memory or concentration improvement. The therapy did produce significant improvements of cognitive learning across a wide scale of diagnosed demented residents.¹⁹ This result is

¹⁷A. Norman Goldwasser, Stephen M. Auerbach, and Stephen W. Harkins, "Cognitive, Affective, and Behavioral Effects of Reminiscence Group Therapy on Demented Elderly," International Journal of Aging and Human Development 25, no. 3 (1987): 209-21.

¹⁸Marian L. MacDonald and Joan M. Settin, "Reality Orientation Versus Sheltered Workshops as Treatment for the Institutionalized Aging," Journal of Gerontology 33, no. 3 (May 1978): 416-20.

¹⁹Ian Hanley, R. J. McGuire, and W. D. Boyd, "Reality Orientation and Dementia: A Controlled Trial of Two Approaches," British Journal of Psychiatry 138 (January 1981): 10-14.

also suggested by Holt and Woods. Alleviation of disorientation in severely demented persons was a consistent finding; however, therapy was less likely to produce beneficial effects of behavioral ability.²⁰

Zepelin, Wolfe and Kleinplatz evaluated a year long study of reality orientation among demented nursing home residents. No behavioral gains were achieved which suggest that reality orientation can return patients to premorbid levels of functioning. Disorientation was prevented in areas of activities of daily living among those residents receiving therapy.²¹

A comparison of residents of nursing homes who display disruptive vocalization with a group of residents who do not display vocalizations was made by Cariaga, Burgio, Flynn, and Martin. The residents who display disruptive vocalization were more likely to need assistance in activities of daily living and show impairments in cognitive status. Dementia was also significantly higher among residents with disruptive vocalizations.²²

²⁰Harold Zepelin, review of Reality Orientation: Psychological Approaches to the 'Confused Elderly', by U. P. Holden and R. J. Woods, In Journal of Gerontology 39, no. 3 (May 1984): 375.

²¹Harold Zepelin, Charles S. Wolfe, and Fae Kleinplatz, "Evaluation of a Yearlong Reality Orientation Program," Journal of Gerontology 36, no. 1 (January 1981): 70-77.

²²Jose Cariaga, Louis Burgio, William Flynn, and David Martin, "A Controlled Study of Disruptive Vocalizations among Geriatric Residents in Nursing Homes," Journal of the American Geriatrics Society 39, no. 5 (May 1991): 505.

Everitt, Fields, Soumerai, and Avorn evaluated the relationship among nursing staff assessments, independent evaluations of physical function and cognition, and psychoactive medication use in a resident specific analysis. Among the residents who displayed agitated behavior, only six percent were known to cause severe distress. The highest incidence of behavior resulted in withdrawal to social isolation.²³

Theoretical Framework

James C. Folsom developed reality orientation therapy at the Winter Veterans' Administration Hospital in Topeka, Kansas in 1959. The premise of reality orientation is that an individual's ability to function adequately in an environment is directly correlated with the degree of orientation to that environment. Complex patterns of behavior and daily routine are developed by individuals from the more basic constructs of time, place, and situation. The absence of positive or meaningful stimulation from the environment results in a deterioration of ability to construct a framework for living.²⁴

Reality orientation is a verbal therapy which uses repetition and recall as vehicles to decrease confusion and

²³Daniel E. Everitt and others, "Resident Behavior and Staff Distress in the Nursing Home," Journal of the American Geriatrics Society 39, no. 8 (August 1991): 796.

²⁴Gropper-Katz, "Reality Orientation Research," 13.

social isolation. It directly addresses confusion, disoriented behavior and memory loss associated with lack of social interaction by repetitious verbal stimulation. Details of time, place, and person are repeated to the individual on a constant basis so that the individual is forced to become aware of self and environment. The verbal instruction is paired with visual stimuli which the patient should recognize through life experiences, such as clocks, calendars, and pictures.²⁵

The goal of therapy is to halt or reverse confusion, disorientation, and social isolation through the relearning of self and environment. Social reinforcement is necessary. Participation in learning by the patient is paramount to success; therefore, the therapy is rooted in behavior sensitive principles which encourage learning. All procedures are explained to patients before participation is allowed, patients are never hurried, and abilities of patients are exploited rather than disabilities.²⁶

The process of repetitive information to the patient regarding person, place, and time provides the basis for reconstruction of an environmental framework of understanding. Intensive information is given to the patient in one format of reality orientation during the

²⁵David R. Buckholdt and Jaber F. Gubrium, "Therapeutic Pretense in Reality Orientation," International Journal of Aging and Human Development 16, no. 3 (1983): 168.

²⁶Ibid.

first twenty-four hours. Twenty-four hour reality orientation provides a means of structuring the environment throughout the twenty-four hour period so that all persons having contact with the patient intervene appropriately and consistently. The patient is given information concerning person, place, and time so that following reality orientation therapies will support initial learning. Ongoing reality orientation therapy, which may or may not be used in conjunction with twenty-four hour therapy, provides repetition and structure for the patient over a longer period of weeks.²⁷

Social interaction and cognitive stimulation are sought throughout therapy. Confusion and dementia are sometimes aggravated by isolation and withdrawal due to inability to comprehend surroundings.

²⁷Linda Drummond, Lorraine Kirchhoff, and Dorothy R. Scarbrough, "A Practical Guide to Reality Orientation: A Treatment Approach for Confusion and Disorientation," The Gerontologist 18, no. 6 (December 1978): 569.

CHAPTER THREE

METHODOLOGY

Setting

This study was conducted at Glenwood Manor, a large nursing home in a suburb of Atlanta. The nursing home is a part of a nationwide health care corporation. The facility has a capacity of 225 beds, and has been a part of the community for over thirty years. Patients having Medicaid, as well as Medicare and private pay insurance, are accepted upon vacancy.

The facility employs over two hundred workers to staff three work shifts. Three social workers are employed to coordinate family and resident interaction. Several services are provided to residents as contracted medical care, including psychiatric evaluations, physician checkups, and restorative physical therapy. The facility is an accepted part of the community, and participates in several community programs. It is also supported by various civic clubs and programs which participate in activities within the facility.

The nursing home serves the entire community, and reflects the racial demographic makeup of the surrounding

area. Approximately sixty percent of the residents are African American, as is the community.

Background of the Study

The subject of this study was Mrs. M. Q., an eighty-six year old patient. She entered nursing home care in 1989. Three years prior to nursing home admittance she lived independently in an elderly apartment setting. Mrs. M. Q. has no immediate family to care for her, but was visited regularly by her brother who assumes responsibility for her. Mrs. M. Q. entered the nursing home due to mental deterioration of abilities. She was later diagnosed with dementia and paranoid delusions.

Mrs. M. Q. was born in 1906 in Rockdale County, Georgia, the oldest of three children. She grew up in a rural setting. Her parents were farmers, and owned a dairy farm. Mrs. M. Q. attended a rural school until seventh grade. She later attended business training courses, but had no other formal training.

The employment career of Mrs. M. Q. lasted twenty-six years as a clerical worker in an insurance company. She married late in life to a man who owned a motor garage. The couple lived together for twenty-eight years until the death of Mr. Q. in 1969. The marriage produced no children.

Mrs. M. Q. cohabited with her brother shortly after the death of her husband. This arrangement lasted 17 years until 1986, at which time Mrs. M. Q. entered an elderly

living setting which encouraged independence. She was very happy for the three years she spent in this environment; however, she lost her ability to ambulate and subsequently entered a nursing home.

There was ample evidence to suggest that Mrs. M. Q. has never accepted her present setting as home. She had frequent complaints upon entering the facility; however, the complaints were based on genuine dislikes of Mrs. M. Q. Approximately six months later she began to accuse staff of abuse.

The accusations of abuse of staff by Mrs. M. Q. were originally investigated. The attention of the Director of the nursing home and investigations by State governing panels and Ombudsman workers were directed toward the resident and immediate staff. The accusations ultimately were found to be false. Mrs. M. Q. continued to voice allegations of extreme abuse and violent attacks by staff toward her. The accusations also contained racially derogatory statements toward staff members and increased in frequency.

Psychiatric evaluations were performed on Mrs. M. Q. which suggested that she had organic brain syndrome. She was diagnosed as having dementia with paranoid delusions.

The accusations of abuse became routine, and followed a schedule. Mrs. M. Q. complained of harsh threats by staff in the mornings (verbal abuse). She complained that she was

not fed her meals at lunch time, and many times she stated she had been severely physically abused in the afternoon hours. On bad days she might voice accusations of abuse frequently throughout the day.

Mrs. M. Q. is confined to a wheelchair, but is physically able to function well in a nursing home setting. She is able to transfer from her bed to her wheelchair without assistance, and enjoys transporting herself about the facility. She maintains normal sleep patterns, and is active during daylight hours.

Long term memory of Mrs. M. Q. is intact; however, she is not able to recall recent events or remember names of staff members.

Treatment Hypothesis

The major focus of this study was that the participation in individualized counseling using reality orientation therapy would increase the resident's awareness of her environment. It was further hypothesized that participation in reality orientation therapy would decrease paranoid delusions as evidenced by fewer allegations of abuse by the resident.

Data Collection Procedures

One outcome measure was used to assess the target behavior. Empirical data gathered by direct caregivers was collected under three categories. Statements of verbal

abuse, of physical abuse, and of the lack of feeding were recorded by direct observation. The time of day in which the complaint was heard was also recorded.

Data was collected by two staff members who provided direct care to the resident. The staff members observed the resident daily and recorded behavior into three categories.

The recording times were limited to hours of the daytime nurses shift, 7:00 a.m. to 3:00 p.m. This ensured that the observers were uniform, and a greater number of staff members were available to alert observers to behaviors of the resident.

Intervention Strategies

Individualized counseling was performed by the researcher in a one-to-one setting on alternating days. The researcher was able to perform therapy inside the nursing home for approximately one hour with the resident.

Counseling of the resident was based on reality orientation therapy. The resident was encouraged to participate in counseling. The specifics of the environment were repeated to the resident several times during therapy. The resident was provided with information of the date, time and season. Spatial objects were used as a topic of conversation and discussion. Index cards with various daily use items were also used for discussion. The resident was encouraged to explain items on index cards which pictured items such as eating utensils, food, and gardening tools.

The researcher emphasized participation by the resident and discussion. The routine of care provided to the resident was also emphasized. Every session included a discussion of where the resident lived, how she came to live there, and what she can expect in care-giving on a day to day basis. The role of staff and expected contacts with staff members were explained. The resident was also given a tour of the facility to conclude each session. The resident was encouraged to provide directions to various locations in the nursing home.

Names of caregivers were given to the resident upon sight of the staff member. These names were repeated into conversation along with the date and time of day. The resident was encouraged to repeat the name of each caregiver and then recall the name after a five minute period. The role of each staff member in relation to Mrs. M. Q. was explained upon visual contact.

The resident and researcher were able to observe a courtyard from inside the facility. The resident was asked to explain the weather outside. The date, season, and weekly weather trend was discussed.

Throughout each session the resident was repeatedly exposed to information pertaining to her present environment. The information was given numerous times and encouraged to be repeated by the resident. The information was then asked for by the researcher after a brief period to

encourage short term memory retention as well as cognitive exploration and participation.

Design

The design used to assess the effectiveness of individualized reality orientation counseling delusional complaints was the A-B single case design. This approach was selected due to the ability of the design to clearly detect interventional changes in behavior. The nature of the study focused primarily on the reduction of an undesirable behavior. The A-B single case design was the most direct method to record any changes in behavioral content.

CHAPTER FOUR

PRESENTATION OF RESULTS

This chapter is a summary of the data collected from the resident in this study. The results of this study are presented in Figure 1, Figure 2, and Figure 3. The resident participated in individualized counseling for a period of nine weeks. Baseline and intervention measures were recorded on frequency of allegations of the resident of verbal abuse, neglect, and physical abuse. Figure 1 presents allegations of verbal abuse stated by the resident during the baseline and intervention phases. During the baseline phase the resident reported allegations of verbal abuse ranging from four to five occurrences daily with a mean of 4.3 (s.d. = .03). The mean decreased during the intervention stage to 3.2 (s.d. = .41). The results indicate that individualized counseling impacted the resident in a positive manner, with a mean difference of 1.1, and a relative decrease of 25.6 percent below the baseline mean.

Figure 2 depicts allegations of physical abuse during baseline and intervention phases. Baseline measurements ranged from three allegations daily to six allegations daily, with a mean of 4.5 (s.d. = .03). The same range of occurrence continued throughout the intervention phase,

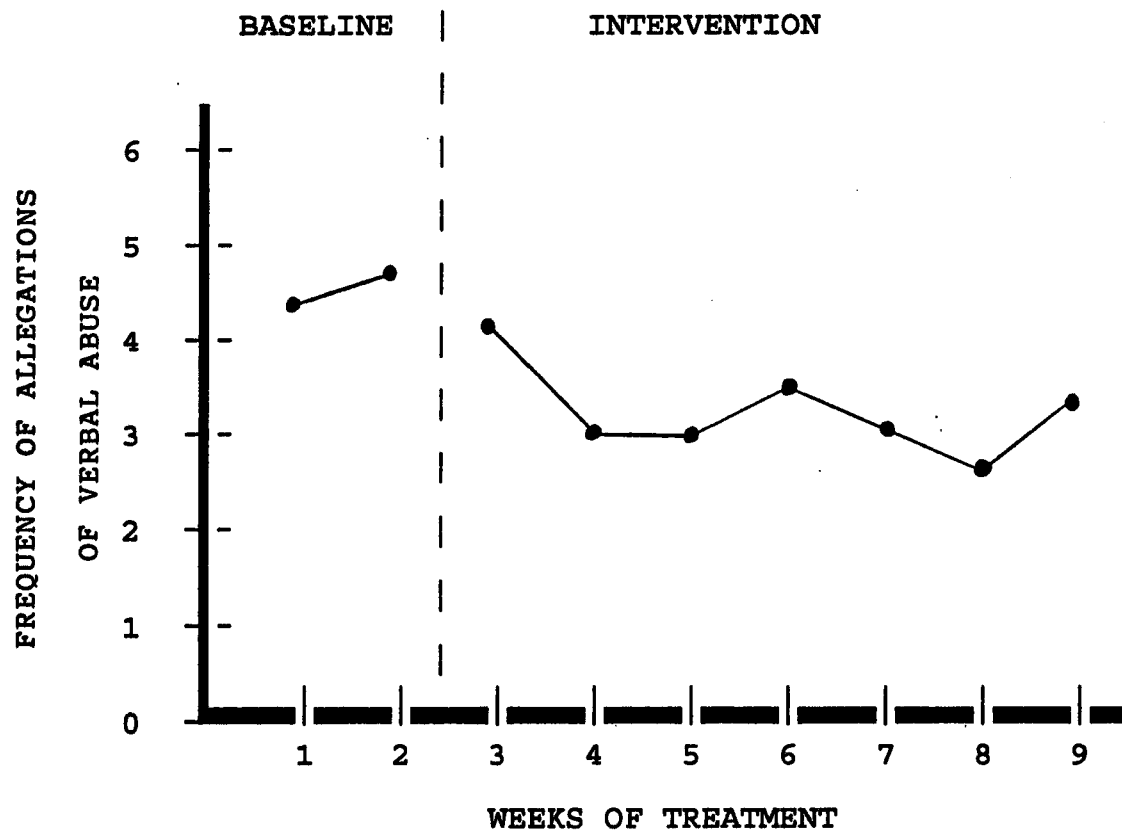


Figure 1. Frequency of allegations of verbal abuse for resident during baseline and intervention stages

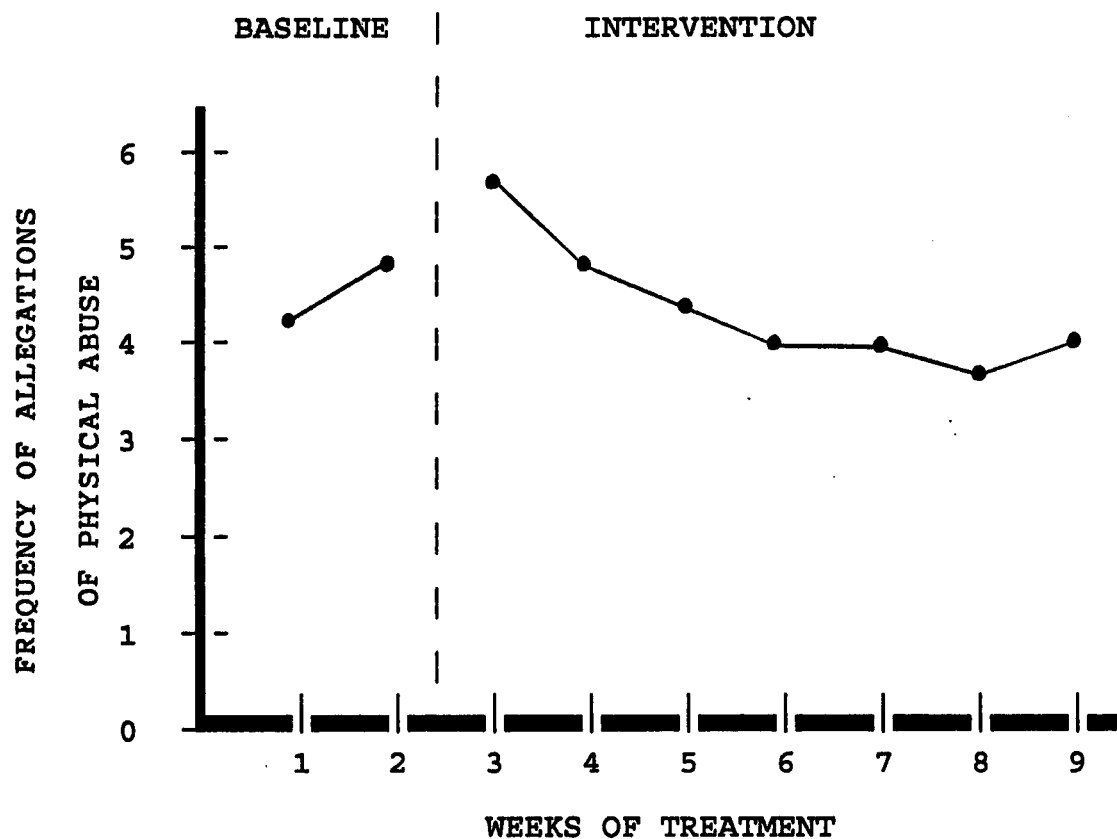


Figure 2. Frequency of allegations of physical abuse for resident during baseline and intervention stages

while results indicated individual counseling was able to produce overall improvement of the resident in ability to distinguish physical abuse from routine care giving. The results showed a mean difference of .13, and a relative decrease of 2.9 percent from the baseline mean.

Figure 3 presents statements by the resident of neglect in caregiving. The frequency of the statements range from zero to three occurrences daily, with a mean of 1.8 (s.d. = 0) during the baseline stage. The mean declined during the intervention stage to 1.06 (s.d. = 1.4). The results show a .74 mean difference, and a 41.1 percent relative decrease from the baseline mean. This decline represents improvement in the ability of resident to determine neglectful treatment towards self.

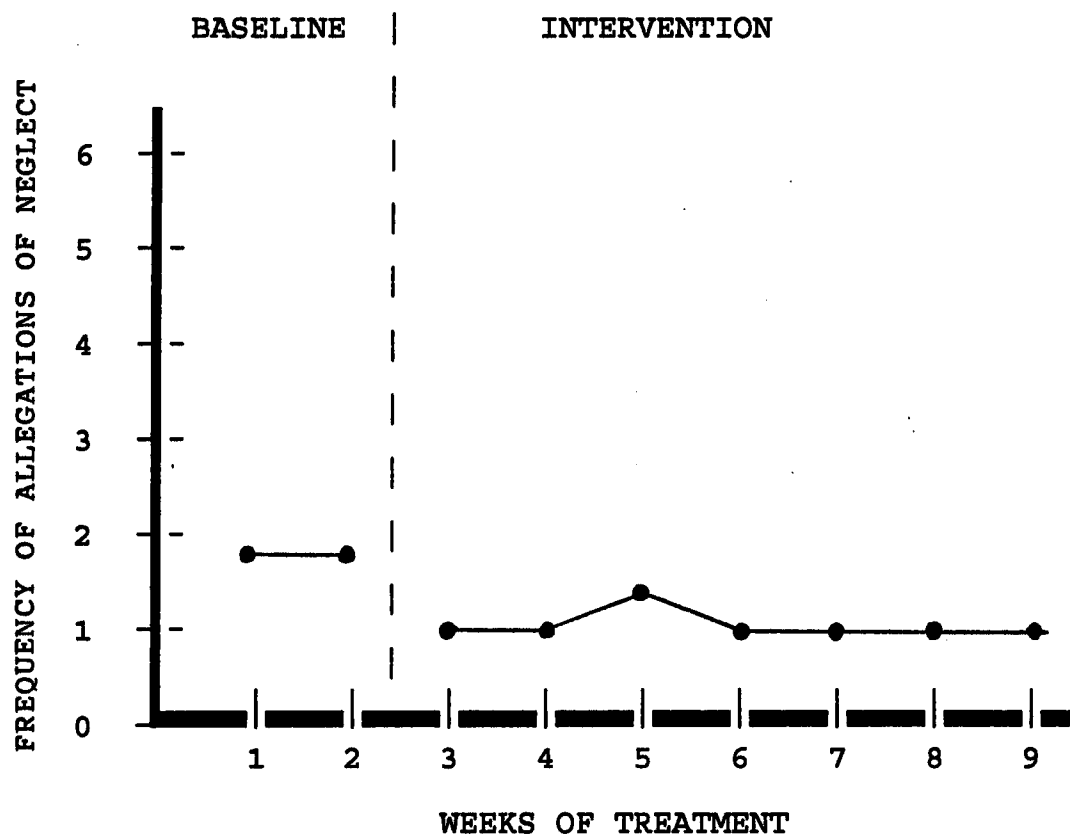


Figure 3. Frequency of allegations of neglect for resident during baseline and intervention stages

CHAPTER FIVE

SUMMARY AND CONCLUSION

In the present study, individual counseling was found to produce a decrease in the resident problematic behavior. All behaviors decreased in frequency as observed by caregivers. Although the quasi-experimental nature of the A-B design does not usually permit casual inferences, visual inspection of the data suggest that individual counseling using reality orientation therapy produced significant improvements in the resident's behavior.

The resident responded to therapy with positive results across multiple behaviors. The patient exhibited decreases in verbal complaints with intervention. It is clear that the intervention was instrumental in effecting the resident's targeted behavior. The resident also showed improvement in areas which were not measure, including a greater orientation to physical surrounding as well as having positive feeling toward placement in an institutionalized setting. The resident decreased negative statements to relatives and eliminated requests to leave the environment outright. Direct caregivers were able to observe a visible change in the severity of the resident's statements which did not manifest itself in the recorded

data. It is possible that the continuation of negative statements was a well practiced habit rather than agitated behavior.

The resident became quick to praise caregivers during intervention. This was also not a measured outcome, although it was a desired result. The most frequent complaint by the resident was failure of caregivers to feed her. The resident showed limited improvement in the actual statements, but began to praise both the food and the caregiver.

The resident displayed cognitive improvement and greater orientation throughout the intervention phase of study. Physical abilities did not appear to decline during this period. The sudden death of the resident, two weeks after the completion of the intervention phase, was unexpected.

Limitations of the Study

Limitations in this study include the lack of individual attention in a nursing home setting able to be focused on the resident to determine improvements. The amount of time able to effectively observe the resident was limited to day shift hours of the staff. It is possible that different results would have been produced by observing the resident throughout twenty-four hours.

There were many hindrances to therapy, including the general health and disorientation of the resident. Therapy

could be performed only on those times in which the resident felt well enough to participate.

The A-B research design used in the study offers less internal validity than do more complex single subject designs, such as A-B-A-B designs and multiple baseline designs. The A-B research design makes no causal references. The strength of A-B designs is in their ability to provide an objective determination as to whether or not a change has occurred in the client's targeted behavior.

A final limitation to this study is the unlikely possibility that some unknown concurrent historical variable was responsible for the observed improvements in the resident's level of orientation and paranoid delusional behavior.

CHAPTER SIX

IMPLICATIONS FOR SOCIAL WORK PRACTICE

The findings from this study suggest that therapy with dementia residents in nursing homes is both useful and prudent. Dementia is diagnosed frequently and across a wide variety of mental statuses of elderly. The very act of diagnosis might become a self-fulfilling prophesy due to the specialized caregiving and lack of environmental stimulation found in nursing homes. Individualized therapy with residents provides both personalized care and specific need fulfillment.

Nursing homes are a recent phenomena of the past twenty years. The number of elderly committed to institutionalized care continues to grow as the industry seeks to define itself. The elderly, meanwhile, are increasing in number and in percentage of the overall population. Presently, few mental restoration therapies exist, either inside institutions or in communities, despite continuing research which shows a variety of improvement in elderly patients receiving therapy. Many therapies are able to be performed by caregivers other than clinicians. The costs are minimal, and the rewards are significant.

The fact remains that most services delivered to the elderly are based on profit.¹ Few social institutions exist specifically for the elderly. This renders the fastest growing group of Americans without necessary and vital services.

Advocacy for the elderly is performed mostly by the elderly and near elderly. Social programs of low cost and availability to the community are needed. Advocates for the elderly should focus on programs which offer physically and mentally restorative therapies. Community based social programs would serve a much needed prevention service to the much greater cost of institutionalization.

Relevance to the Agency

This study gave the researcher the opportunity to perform individualized counseling with a dementia resident in a nursing home setting. The resident benefitted by the counseling which reduced problematic behaviors across three categories. The nursing home, which depends upon profit for survival, is understandably concerned with cost effective care for residents. Reality orientation therapy is able to be performed by virtually all existing staff members with minimal training. The tools are inexpensive and many already exist in the setting such as clocks and calendars.

¹Marion Bogo, "Social Work Practice with Family Systems in Admission to Homes for the Aged," Journal of Gerontological Social Work 10, no. 1 (January 1987): 6.

The allocation of a staff member to perform therapy, specifically group therapy, using reality orientation could possibly reduce problem behaviors in residents which require greater staff care. The effect of therapy would therefore produce greater mental and physical functioning by the resident, thus improving the quality of life while simultaneously reducing the work of direct caregivers who must compensate for inabilities in residents.

APPENDIX A

COMPLAINT TALLY

MONITOR NAME: _____

DATE: _____

	DID NOT FEED	PHYSICAL ABUSE	VERBAL ABUSE
7:00 A.M.			
8:00 A.M.			
9:00 A.M.			
10:00 A.M.			
11:00 A.M.			
12:00 P.M.			
1:00 P.M.			
2:00 P.M.			
3:00 P.M.			

COMMENTS: _____

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